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ABSTRACT

The author discusses some of the conflicts now facing professionals, particularly those who work with children in the mental health field. He focuses on three conflict areas: the enormity of the task, the best method or theory involved in problem solving, the counselor's need to rehabilitate the patient vs. the need for social changes. The author concludes, however, that despite these conflicts, child mental health workers are moving into a progressive and more enlightened era. (HMV)

The Fifth Annual
Seymour Vestermark Memorial Award Paper

CONFLICTING NEEDS AND MODELS IN RESPECT TO THE DELIVERY OF MENTAL HEALTH SERVICES FOR CHILDREN

by

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NATIONAL INSTITUTE OF MENTAL HEALTH

The Seymour D. Vestermark Memorial Award and Lectureship established in 1969 jointly by the National Institute of Mental Health and the American Psychiatric Association

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FOREWORD

The Seymour Vestermark Memorial Award was established in 1969 by the National Institute of Mental Health and the American Psychiatric Association to recognize notable contributions to undergraduate and postgraduate medical education, to continuing education, and to the education of behavioral scientists.

The 1973 award, presented at the APA annual meeting in May, 1974, honors a prominent educator in the field of child psychiatry, Dr. George Edward Gardner, Professor of Psychiatry Emeritus at Harvard Medical School and Director Emeritus of Judge Baker Guidance Center in Boston, Massachusetts.

Dr. Gardner has helped focus national attention on the need for child mental health professionals trained for service in a variety of nonpsychiatric child care settings as well as the traditional clinical settings. He has long been in the forefront in developing training programs relevant to today's needs and, in his paper, raises issues to be considered in further improving educational programs for all professionals dedicated to the health and mental well-being of today's and tomorrow's child.

We, at NIMH, share Dr. Gardner's concern and have set child mental health as one of our top priorities. All of the Institute's efforts—from basic research to training to community consultation—include components specifically designed to help meet our children's mental health needs. And we, too, will continue to strive to expand and improve all programs to promote the mental health of this country's children and, indeed, of the world.

BERTRAM S. BROWN, M.D.
Director
National Institute of Mental Health

PREFACE

I am the fifth person selected to receive the Seymour Vestermark Memorial Award by the joint committee of the American Psychiatric Association and the National Institute of Mental Health. I am deeply honored.

Dr. Seymour Vestermark's primary (but by no means sole) professional interest was the establishment and continuance of high standards of education and training for those men and women who eventually were to practice psychiatry. He gave himself unstintingly to the furtherance of this interest and aim through advice and consultation—and through exacting demands when these were felt by him to be necessary. The field of American child psychiatry was aided significantly by Dr. Vestermark as it strove for universally agreed-upon training standards and for professional recognition.

But Dr. Vestermark's great accomplishments in themselves do not reveal his true character as a man and as a physician-friend of those who knew him. All men from their earliest years, consciously or unconsciously, set up classifications of men—and in this respect I am as are all others. In my own classification system men and women of the highest excellence are placed in my salt-of-the-earth category, and in this very select category many years ago I placed Seymour. Such men are devotedly competent in their chosen field of work but they also are kind, friendly, and compassionate. When critical of others they are critical only to be helpful—and to be helpful seems to be their basic motivation in all their dealings with their fellowmen.

Such a man was Seymour Vestermark.

G.E.G.

April 1974

Conflicting Needs and Models in Respect to the Delivery of Mental Health Services for Children

The field of child psychiatry in America at the present time is beset with many serious and differing issues and conflicts that confront child psychiatrists as members of a medical specialty but that also confront their colleagues in the other child mental health professional groups.

In this discussion I shall not deal primarily with the larger community or societal issues but shall comment mainly upon those conflicts that emerge within the thoughts and the feelings of these professionals themselves—conflicts generated by the immediate past and current historical movements in American society.

Of all the issues confronting child psychiatrists (and indeed all trained child mental health personnel) at this moment I have selected but one, namely, the *anxieties* that seem to beset these professions. These anxieties have their origins in the postrevolutionary era (with its revolutionary spirit) in which child psychiatrists find themselves. They are: (1) anxieties arising from the almost limitless demands placed upon child psychiatrists for a demonstration of professional expertise in almost limitless specific areas of child mental health; (2) anxieties resulting from abrupt changes and questioning in respect to the alleged importance and relevance of the bodies of knowledge or schools of thought from which in the past have been drawn our methods of approach and to which we have had only a mildly questioning allegiance; and (3) anxieties generated by different, and possibly conflicting, roles that professionals should play in respect to the delivery of mental health care. I shall deal first with the revolutionary scene as the generative factor and then, in turn, consider each of these three anxieties.

In a most general sense, I have been struck by alternating feelings of optimism and pessimism among child mental health personnel—optimism in respect to the glorious extent of the ideal toward which they now strive and pessimism in respect to the shortcomings of their attempts at the achievement of that ideal.

I know of no better lines to describe the present scene than those written by Charles Dickens in his opening paragraph of *A Tale of Two Cities*, depicting the revolutionary "time" of 1789:

> It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of Light, it was the season of Darkness, it was the spring of hope, it was the winter of despair, we had everything before us, we had nothing before us, we were all going to Heaven, we were all going direct the other way—in short, the period was so far like the present period, that some of its noisiest authorities insisted on its being received, for good or for evil, in the superlative degree of comparison only.[1]

I choose these lines deliberately, for the current scene has much to do with the origins of what those in the field of child mental health now hope for our children, and much to do with the anxieties relating to whether or not they shall realize those hopes.

In the first place it is well to realize that in the decade of the 1960s we were involved in a revolution in America—a revolution that was as deeply significant (or even more so) as that one in which we engaged in the elimination of foreign authority over us or that one (the Civil War) in which we just narrowly kept the United States as one Nation. We are still trying to realize some of our hopes and expectancies of that last revolution. It was a revolution that demanded equality and equity for our essentially disenfranchised, prejudiced-against blacks and our socioeconomically oppressed whites.

[1] Punctuation and capitalization are Dickens' original. See *Harper Modern Classics* (Dickens, pp. 2, 3). Harper and Row, 1958.

But over and beyond these specific nodal points or thrusts of the general revolution—as is ever to be expected in the climate of a *general* revolution—there are associated revolutions pervading many other groups in our society, each of which insists that its unmet needs are paramount in importance and should be met first—and fully. Our university students strove for freedom and for a voice in the governance of university affairs (even to the selection of their professors). Many of our high schools were functioning (really functioning) at about two-thirds time due to student unrest and demands for administrative and curricular changes. The Women's Liberation Front took to the streets in demonstrations and parades to demand equality with men in all the affairs of life. The members of the Gay Liberation Front were no longer characterized by feminine passivity and docility for they too had activist groups that demonstrated and made their demands known.

Again, some of our youth groups were led by good, constructive, and dedicated leaders of high ideals; other groups were led by leaders bent on the destruction of society with the assurance that they could (and would) make a better society for all people. (And there were groups with leaders halfway between these two extremes.) We are still fighting a serious drug problem among youth—with all and any methods that we hope will be efficacious.

All of this societal unrest—with all the stridency of their vocalizations, the disrespect for authority of any type (parental, religious, police, governmental) and the militancy of their methods would seem to be enough, in and of themselves, to create unregulated, incessant turmoil. But beyond all these (and inextricably involved with all of them and by no means a minor all-pervasive causative factor) is the fact that for 10 years we were involved in a war in the Far East—a war that was the most unpopular and most hated war in our history. It killed somewhere near 50,000 of our youth and injured 200,000 more. It wrought destruction on people and their lands. And it usurped our tax payments in a defense budget that amounted to $70 billion a year. Very few of our citizens knew exactly how or why we got into it in the first place, and it took three different Presidents (and six Congresses!) to figure a way to get us out of it!

May I add that unemployment rates in some of our great cities still run as high as 8 to 9 percent of the male population.

I cite this picture of America, this scene—getting worse in each of the years in the 1960s and not yet entirely ameliorated—as background material in the light of which we will better understand some of the changes in philosophies and conflicts in professional interests with which we are confronted in trying to deliver adequate mental health care to our children—and to understand particularly the emotional "set" and thinking of mental health personnel who are to do that delivering.

My thesis is that because we still are responding to the demands for change of these revolutionary times, we who work in the mental health field are now faced with many serious professional conflicts—conflicts generated by a revolution's demands for drastic and quick and all-inclusive changes and emphases—, conflicts which will not be solved easily nor in a short space of time. In citing some of these conflicts, when I use the term "child mental health professionals," although I refer primarily to child psychiatrists, child clinical psychologists, and social workers, I am by no means excluding other professional groups dealing with children, specifically teachers, children's courts personnel, pediatricians, and a host of others.

I

The first conflict that confronts the child mental health worker today results from the enormity and the expectancies in expertise that the revolutionary public at large has set for them over the past decade—great expectancies in expertise set by the public that continually create a sense of inadequacy in the mind and heart of mental health professionals, who know

that they just cannot meet all the demands for the adequate solution of child mental health needs in the multiple and complex situations confronting them. They are expected to be all things to all types of needful children and to involve themselves wholeheartedly and effectively in a host of differing professional projects and programs.

However, these expectancies on the part of the public really do outline for us in clearest relief the great mental health needs of children and they constitute a blueprint for the future. Even though they at the moment set problems and conflicts for and within us, they constitute agreed-upon and hoped-for ideal care. I shall emphasize these inordinate expectancies in the functioning of child mental health personnel by merely citing the various and multiple settings in which child psychiatrists are *expected* to play their roles —some in center stage front, many more in support of other members of the cast.*

A. The various *types or structures* of mental health clinics or child psychiatric clinical settings in which health services (in this case, treatment) are to be rendered to the public are as follows:

1. The traditional nonaffiliated community child guidance centers (nonaffiliated with children's hospitals or children's medical services of a general hospital)

2. Affiliated community child guidance clinics (i.e., those affiliated with medical centers, pediatric services in general hospitals or children's hospitals)

3. Child psychiatry units or divisions in a general hospital or a children's hospital operated under the overall budgetary direction of (a) departments of general (adult) psychiatry, (b) departments of pediatrics, or (c) (rarely) under the aegis of departments or divisions of neurology or chi'd neurology

4. Independent or affiliated inpatient child psychiatric treatment centers or residential settings

5. Child psychiatric divisions in community mental health centers

6. Child psychiatric divisions within the recently established satellite ambulatory medical clinics in some of our cities

These are the public's expectancies in expertise solely in the various *clinical* settings in which mental health personnel are to make their contribution. These are but a part of the demands for service to meet children's needs.

B. Let us look at the needs to be met in nonpsychiatric settings that offer services for children. Child mental health expectancies in nonpsychiatric (extramural) child care settings are as follows:

1. Juvenile courts
2. Detention homes
3. Juvenile correctional institutions and industrial schools for boys and girls
4. Child protective agencies (S.P.C.C.)
5. Schools for the mentally retarded
6. Nursery and preschool settings
7. Group foster homes
8. Private schools
9. Schools for blind children
10. Schools for deaf children
11. Psychiatric camps for children
12. Family agencies
13. Child adoption agencies
14. Child placement agencies
15. Public school counseling services

* Cf. Gardner, G. E. The Present Day Scope of Clinical Services in American Child Psychiatry. In: Adams, Paul; Work, Henry H.; and Cramer, Joseph B., eds. *Academic Child Psychiatry*, 1969.

16. Youth service boards
17. Residence schools (or classrooms) for emotionally disturbed children.

I submit that these are real and urgent present-day needs for mental health personnel to meet. At the moment it is impossible to meet them.

C. If one turns from all this to just an outline of the present-day service expectancies from mental health personnel in a children's hospital or in a pediatric service of a general hospital, the list of needs is impressively, perhaps overwhelmingly, extended:

1. Child psychiatric service is expected on all medical and surgical inpatient wards of the hospital. It must be offered by permanent assignment of personnel or by on-call child psychiatrists to medical and general surgical outpatient clinics and to emergency clinics of both disciplines. (It is to be remembered that surgical inpatient services in most children's hospitals include differentiated general, neurological, orthopedic, cardiac, and genitourinary surgical wards.)

2. To complete the picture of called-for and expected child psychiatry service in a children's hospital, one has to include also the following specialty clinics and categorical disease clinics where many children with allied and important emotional components are treated:

a. Metabolic disorders clinics (or wards)
b. Endocrine dysfunction clinics
c. Diabetes clinics
d. Cerebral palsy clinics
e. Genetic counseling clinics
f. Mental retardation clinics
g. Educational evaluation clinics
h. Speech and hearing clinics
i. Allergy clinics
j. Adolescent (medical) clinics
k. Clinics for children with congenital defects

I submit that even with the greatest emphasis upon the generic approach in the education and training of the child psychiatrist—indeed, of any of our child mental health care personnel—we can never devise a program that will assure the trainee that he or she will be able to function effectively in all of these areas of child demands and needs. But my thesis is that, because we can't, we are beset by conflicts and resulting anxieties, conflicts generated not by us who know our limitations but by the public who knows (and is rightfully aroused by) the continuing unmet mental health needs of children in all of these settings.

3. A third area in which anxiety-genic conflicts develop—and in this paragraph I refer mainly to the child psychiatrist (and possibly Ph.D. child clinical psychologist)—arises in respect to the multiple, perhaps conflicting, discrete, and specific services that the child mental health expert is supposed to be trained to carry out effectively for the children under his care in all of these settings that I have just cited. Let me list some of them for you.

a. Diagnosis. (Requiring a determination of the nature and severity of the emotional disability with a selection or ordering of treatment to be delivered)

b. Consultation. (Demanding expertise in crisis intervention and utilization of nonpsychiatric physicians and nonpsychiatric paramedical disciplines or mental health personnel)

c. Again, in treatment services themselves, the treatment modalities in the application of which he is supposed to be expert can be listed:

(1) Intensive individual psychotherapy
(2) Individual supportive psychotherapies
(3) Family therapy
(4) Group therapy

(5) Psychopharmacology
(6) Behavior therapy
(7) Educational therapy (alone or in conjunction with any of the above therapies)
(8) Child psychoanalysis (possibly)

I submit again that no individual mental health worker in any of our disciplines can be trained to do all these things, and the realization that they cannot do them all makes for inner conflicts at this professional historic moment. As month follows month and the revolution depicts more and more discrete groups in our society (e.g., the more recent demand for changes in our treatment of prison inmates) that need more and better health care—and each with a seemingly higher and higher degree of specialization in care—our anxieties are escalated to even higher levels. All of us want these needs to be met for, as I stated above, they will when met constitute ideal mental health care. But even an agreement or consensus on priorities cannot be arrived at, nor do needed governmental resources seem available; and a pervasive pessimism is abroad.

Yet active and significant steps are being taken by our leaders to order sensible priorities for all these overwhelming, but just, expectancies made visible at last. I refer here to the establishment of new health delivery models, to the combined efforts toward solutions by physicians and social and health engineers, and to the establishment (specifically pertinent to our field) of a consortium of representatives from many of our national organizations concerned with all aspects of child development and child health. The positive results of the vision and the strength of such an instrument may again replace our pessimism with a feeling of realistic optimism.

II

In addition to these conflicts generated by a cognizance of these unmet needs of children and by the stridently voiced and insistent demands of our revolutionary society, there are other conflicts that beset us in the child mental health field. I refer here to the deeper and more poignant issues within us as individuals concerning our basic thinking and orientations of the truths we hold (or have held) in regard to child development and child mental health care. I refer here specifically to the wars that seem to rage about us at the moment in respect to the basic problem: What *body of knowledge* is of the most worth?

A. We note a waxing of interest in (and hope in) the field of genetics at the very moment that it is demanded of us that a major portion of our efforts be dedicated to the tenets of the "experiential school," with its stated need for an all-out attack upon the familial social and economic ills that are deleterious to child development and child mental health. To which school shall we adhere in our basic orientation?

B. Secondly we note the rise (or the resurrection) of behavior theory that involves as a treatment modality a studied disdain for the individual child's historical past—an approach that is a complete anathema to many mental health professionals.

C. In the third place, one sees the extraordinary research efforts of the academic schools of developmental psychology in our various universities with a primary interest in cognitive development and precision learning in children, with but a secondary or token interest in the emotional determinants of behavior that embrace the extremely important item of motivation. For many professionals this interest is new and foreign as a primary child development issue, and to encompass this body of knowledge looms for them as an impossible task.

D. Fourthly, I shall but mention the growing interest in the possible remedial products of the psychopharmacologists. This, together with the results of

genetic studies and the biological and physiological studies of mentation, initiates within us the gnawing notion that, after all, possibly all the behavioral deviations in many may soon be proven to be caused by organic-cellular dysfunctions and that psychology will one day be relegated once more to its original academic home in philosophy.

E. Finally, and perhaps centrist in importance to many, one notes a marked decline in the interest in psychoanalysis and the developmental parameter elucidated by the findings of this school in the last 80 years.

The various items that I have commented upon to this point, to my mind constitute, in the aggregate, the "winter of our discontent" and generate within present-day child mental health personnel major or minor conflicts and anxieties (serious in some; recurrent and fleeting in others). My remarks in toto, I feel, register the differing expressed anxieties and concerns that have been shared with me by many highly trained and experienced mental health professionals in the immediate past years. The importance of these anxieties is not solely in their effects upon the individual mental health worker; these anxieties are also important in that they are interfering with our getting on with the job to be done.

The crucial question that arises in my mind is, Do we need to victimize ourselves with these disabling anxieties, questioning the validity and practical usefulness of our ideological allegiances, our adherence to a particular school identity in relation to our dedication to our own priorities and preferences in our day-by-day operations in the child mental health field?

My own answer to this question it that we do not, and I shall endeavor to replace pessimism with a feeling of optimism! Seriatim I shall note what to my mind is the ever-recurring and transient nature of the conflicts arising in the area of our ideologies and then deal with optimisms relating to the current scene.

First of all, then, I will play a psychiatrist's true role, i.e., to allay anxieties in individuals rather than to create them! It is to those who are heavy-laden because of the newly expected sophistications in radically new fields of knowledge that are demanded of them that I direct these initial remarks of optimism. The therapeutic device that I will use is the exploration of certain professional events and changes occurring on the American scene in the fields of psychology and medicine in the past 45 years. These remarks can be subsumed under an additional title (or subtitle) "Cycles I Have Lived With." Let me cite a few of them.

1. In 1926, when I entered the Graduate School at Harvard, behaviorism (of the Pavlovian and John Broadus Watson type) was in the ascendancy. If you were not a behaviorist, you were a "nothing"; and implicit, if not explicit, "reinforcers" brought everyone into line. In the aftermath of the tragedy of World War I there was a revulsion at the thoughts generated by history in general and a dedication to the supposed proven fact of the utter uselessness of introspection in the understanding of (or for doing anything about) the conflicts and the disabling behavioral responses of the individual. Professor William MacDougall was figuratively driven out by this academic climate and took a professorship at Duke. Psychoanalysis, too, with its emphasis upon the individual's past history was considered the epitome of the introspectionist school and, if mentioned at all, was mentioned merely to derogate it.

However, in less than a decade the behavior school crumbled under the impacts of the Kohler-Koffka gestalt school and the growing interest in psychoanalysis. It was again deemed pertinent and necessary to consider what was taking place in those areas of the central nervous system between the stimulus and the response if you were to understand and help people. As a

treatment modality, and as the single all-embracing theory of learning, behaviorism was figuratively driven underground in the American universities in general, and it was driven underground literally to the basement of Memorial Hall at Harvard!

Yet, in the 1960s the basic and major theories and tenents of this school of psychology have emerged again and hold an increasingly significant place in the clinical field.

2. In the 1920s and 1930s we became aware of the existence of a psychologist named Jean Piaget in Switzerland, who was neither a behaviorist, a Gestalten nor a Freudian but who was concerned primarily with the cognitive parameter of development in children. As his very significant books emerged, one after the other was bought and dutifully placed in individual and university libraries. For nearly 30 years his books rested there, and their author was known only as "that psychologist in Geneva." Piaget lived a forgotten scientist, and cognitive development was a very minor issue or interest. But scores of child mental health professionals today esteem the works of Piaget as "biblical" and consider cognitive development to be of crucial importance in child life!

Let us turn from the field of psychology to that of medicine, specifically the specialty of psychiatry. I shall cite additional cycles, different but highly related historical events, that should allay the anxieties of some, and I hope will stimulate conjectures in all regarding the future.

3. In the winter of 1929-1930, I, a clinical psychologist at McLean, was taken to a scientific meeting of the Boston Society of Neurology and Psychiatry. As is the custom in many such societies, a brief business meeting was held before the presentation of papers. In that business meeting I witnessed the rejection of the application for membership in the Society (for the second time) of a psychiatrist of international reputation. It was explained to me, in my unsophistication in such affairs, that he was not admitted because he was "one of those Freudian psychoanalysts."

4. At approximately the same time (then a clinical psychologist at the Massachusetts General Hospital) I was privy to the information that there was a heated and prolonged discussion in the faculty meeting of one of our medical schools relative to the appointment of a young psychiatrist to an instructorship in the school. The controversial issue was that this young psychiatrist was a trained and avowed psychoanalyst and that a man with this ideological orientation was not worthy to take a place on the faculty. He, too, became world-renowned!

5. It was shortly after this time that I made my first appearance (by invitation) upon the stage of any professional society. By this time I (though unanalyzed and untrained) was known to psychiatric and pediatric colleagues to be a "radical Freudian" psychologist. Because of the antagonism to this school and the hope that a merry fight would result, I was asked to discuss a paper by a nationally known pediatrician entitled "The Menace of Child Psychiatry." I carefully prepared a discussion of the paper with emphasis upon the premise that a thorough appreciation of the psychosexual development of the child as outlined in Freud's works could be of great help to the pediatrician in understanding some of the emotional and behavioral disabilities of his patients. I need not dilate upon the pediatrician's reply or comment upon the reception of my pro-Freudian remarks by other discussants. The best comment on this incident resides in the fact that his paper was published without my discussion, and his paper is still considered a classic. (Only years later as an intern and resident in pediatrics did I become aware of the fact that he was one of the leading pediatricians of the North American continent! Youth really can—and does—rush in where angels fear to tread!)

In the face of such resistance and antagonism toward the psychoanalytic body of knowledge and the psychoanalytic treatment modality in the 1920s

and 1930s, what happened to both on the American psychological and psychiatric scenes? I shall summarize.

1. In 15 short years the psychoanalytic school became the dominant body of thought in psychiatric thinking. The absolute ascendency of psychoanalysis following World War II was so fixed that by 1955 to 1960 it would have been almost impossible for a psychiatrist to obtain a professorship in psychiatry (or a chairmanship of a psychiatric department) in an American medical school if he had not been a trained psychoanalyst.

2. In the same decade the departments of psychology in all of our universities included courses in psychoanalysis, and scores of psychologists, sociologists, and anthropologists sought psychoanalysis and psychoanalytic training here, or in the more receptive centers abroad.

And now, 15 or less years later, the meter indicating the accepted high evaluation of this body of thought seems to have swept downward again. I am told that at the present moment probably no psychoanalyst could become a professor if he were only a psychoanalyst; i.e., if he did not display, in addition, a fair to outstanding research and publication record in one of the basic sciences, e.g., physiology, genetics, biochemistry, et al.

These are remarkable turns of events that I have cited of the ascendencies of three schools of thought that were (or now are) bases of our diagnoses and treatment of children, namely, the behaviorist, the psychoanalyst, and the Piaget. Do I not, in addition, perceive in the latest literature and hear from my students of this last semester of the re-emergence of the Gestalt school of the 1930s—and this time as a new modality of psychotherapy—the Gestalt school that once helped to give the behaviorists the coup de grace!

Such are the vagaries of the lifetimes of disparate bodies of knowledge. In the realm of hearty acceptance of ideas and concepts and then the subsequent declines of theories of human behavior, these varied ascendencies indicate that they seem to have a lifespan of less than one generation.

Why have I reviewed this history? I have reviewed it (as I emphasized above) to alleviate anxieties referable to the present-day child mental health worker's preferred basic body of knowledge. My thesis is that many professionals in the field of child mental health have become victims of anxieties, and it has been my psychiatric role to alleviate them. One of these anxieties was a challenge to the adequacies in application of what they "know." The other source of anxiety resided in the modern-day challenge of the manner in which they should act; i.e., What is the method of delivery of child mental health care that is of the most worth? I have thus far dealt with the first anxiety and shortly will deal with the second.

But before I do, let us turn our attention to the possible causes of the rise and fall of psychological and psychiatric schools of thought that periodically hold the center of the stage, then are banished to the wings, only later to emerge in the principal roles of the psychodynamic-psychotherapeutic drama. Obviously it is true that all of these orientations embody some important truths, but even more apparent to all of us is the fact that none of them comprises the total answer to factors of development, learning, and adjustment.

Moreover, it is easy unthinkingly to designate these alternating emphases as "cycles" in the sense that they emerge in forms identical with their forebears. These ascendant theories, ideas, concepts and schools re-emerge for periods of ascendancy always with a modification of their original positive or negative enthusiasms and excesses.

Four factors are at work to effect these cycles—or, if you prefer, spirals—of ascendancy in schools of thought and their applications.

1. In the field of the exact sciences the establishment of what is true is attained through rigidly adhered to replication of the original experiment. But in psychology and the social sciences the truth is approached not through repli-

cation (because of the complexities of human behavior) but through relatively sudden and abrupt periods of harsh and partially (and initially) destructive re-evaluations. These inevitable periodic re-evaluations emerge because of the fact that whereas the exact sciences deal with the proof or disproof of a set of facts, in the psychological and social sciences the aim of the scientist is to create a better model to embrace and to explain the facts already obtained—facts assembled by himself and by all other reputable investigators in the same field (e.g., human behavior) of present and all past time.

2. Though every model that I have known has striven desperately to embrace all the normal and abnormal responses in child and in man, none of the model-builders has been able, convincingly, to turn the trick. There are certain inadequacies (and hence vulnerabilities) in *all* of our body-of-knowledge models, and hence they are (and always will be, I hope!) open to academic attack—but attack and hoped-for destruction mind you, primarily along the isolated and particularized (perhaps minute) structural fault in the model. And as long as these model-faults exist, and as long as we can maintain a thoroughly free academic climate, these attacks on models at the hands of new investigators will continue, and repeated re-evaluations will continue. If this freedom is not maintained, we are doomed to patterns of accepted thinking that would destroy our progress.

3. The cyclic aspect of the ascendancy of any body of thought concerning human behavior may not have its basic determination within the walls of the academy. The academy (i.e., the University) is not impervious to the abrupt and vital changes that evolve in society in general—seemingly far removed from the academic laboratories and seminar rooms. As I review the cycles that I have mentioned, it is pertinent to note that these marked and about-face changes in emphasis and in the ascendancy of the various schools in relation to the models that I have mentioned come into being as accompaniments or as immediate sequelae to severe national anxieties and traumas, in our society as a whole—traumas such as World War I, the revolution of the middle and lower middle-class white American laborer resulting in the worthwhile New Deal of Franklin D. Roosevelt of the 1930s, the trauma of World War II and finally, the present revolutionary period (mentioned above) relating to the needed betterment of our political and socioeconomically disenfranchised group of black citizens and citizens of other minority groups. The rise and fall of ideologies and their basic tenets can be charted, quite sensibly, in relation to these societal traumas and the hoped-for alleviations of them.

4. Finally, if I were to try to envision just what are the isolatable ingredients of these traumas (war and revolution) that effected changes in emphases and made for assaults upon the prevalent ascendant models of thought regarding human behavior at that traumatic or revolutionary moment (including the present), I would postulate that they reside along the lines of the convinced relative importance of the betterment of the individual versus a dedication to the betterment of society that, in turn, will modify the afflictions of the individual. And, secondly, (perhaps even basic to it) the relative emphasis upon the importance of the past history (individual developmental history, if you will) versus the feeling that the basic attack is not to be upon the *individual's* problem through an understanding of his past but upon the deleterious aspects of society that make for the disabling responses of whole groups of people.

The ascendant model of thought at the moment, therefore, embraces a low level of value placed on the individual's childhood developmental history and a high value estimate upon cross-sectional individual immediate symptom therapy—and the highest evaluation upon necessary changes in the environments of all. To this latter emphasis all of us must respond if we are to play our part in the eventual betterment of all.

To summarize—and hopefully to allay your anxieties as to what you should "know" as child mental health professionals—may I state that in

the exact sciences eternity is the lifetime of truth. In the social and behavioral sciences, however, truth is approached not through exact replication but through periodic re-evaluations of our basic tenets—and these healthful re-evaluations are usually reactions to certain lacks or faults in our applied bodies of thought. And, finally, I would state that these faults and shortcomings become visually and blatantly much more apparent to us in national traumatic situations or in internally generated revolutionary times. We have been living in these latter times for a decade!

III

Having tried to allay anxieties about the bodies of thought and treatment modality that child mental health workers have embraced and that seem temporarily to be open to attack and possibly destruction—let me move very briefly to the concern about the newer demands upon them to alter the method of attack (in the everyday clinical approach) upon the emotional and behavioral disabilities in childhood. It is, in short, the aim to rehabilitate the individual patient in the clinic or private office versus the demand that workers mount the barricades and do what is fundamentally and basically important, namely, to change the society as a whole that generates the problem in individual child after individual child that is referred for help.

Without for a moment taking sides in this issue, may I again cite a possible cycle in force—a cycle that again has been determined by the progressive traumatic and revolutionary events that have affected our society. (Incidentally, one could say that only in a democratic society such as ours could all of these healthful alterations in allegiances to basic philosophies take place.) But there is a cycle not only in what child psychiatrists shall *know* and *profess*: there is, indeed, an anxiety-genic cycle in respect to what they shall *do*—clinically do!

The third conflict, therefore, among professionals in the broad area of the healing arts at the moment concerns individual role choices and dedication relative to what shall be the best method of the *delivery* of that care that the physician (and specifically the child psychiatrist) can give. Specifically, it becomes a sharp conflict within them as to their present and future identity. Are they to consider themselves as clinicians treating the mentally ill, the maladjusted, the emotionally disturbed, and the educationally deficient child? Or, contrariwise, should they abandon their clinical identity and become essentially social scientists and social engineers and work primarily for the eradication of the ills in society—poverty, racism, poor housing, pollution—or any other four horses of the Apocalypse that beset, downgrade, and defeat both children and adults?

The point and thrust of this serious conflict reside in the fact that present-day child mental health personnel (unless, possibly, they are under 30 years of age) were trained primarily to help *individuals* or, at most, small groups of individuals that in the aggregate comprise a family. But a major portion of all of our health services (including mental health) have become partially involved in the overall civil rights struggle. Advocates of this development emphasize that the really pressing health problems of our poor white and black ghetto children are not those of extraordinary and devastating clinical illnesses or epidemics, but rather those that I have mentioned above—poverty, malnutrition, poor housing, and inadequate education. It is held that out of these conditions the mental health problems of children emerge, and merely to treat the casualties of such social conditions is too small and too inconsequential and too costly a role to engage the major contributions of health personnel. And they could be right! At any rate, even if only partly right, a severe conflict results in the minds of professionals.

There is (as a result) the specific conflict about the desirability of applying the traditional medical model in meeting child mental health needs as op-

posed to the newer approaches embedded in the community mental health center approach. The traditional medical model approach is basically an individualized approach. It demands the most accurate diagnosis possible of the individual child patient and it demands the selection of a specific treatment modality best suited to the alleviation of that particular patient's condition.

The newer community mental health center approach, by contrast, is essentially an epidemiological or public health approach with emphases upon the determination of the prevalence and incidence of children's mental health problems, upon prevention, upon early detection and intervention—intervention hopefully on a scale far larger than that subsumed under the *individualistic* approach of the traditionals. The child psychiatrist is no longer expected to carry out these services as an individual. On the contrary, it is held that his primary and most important job is to work through others—through other personnel (psychiatric and nonpsychiatric)—and particularly through differing social agencies and schools. To which approach is the child mental health specialist to be dedicated in order to do the most good for disabled children? This is another conflict (specifically a problem in *treatment applications*) to which all of us have been subjected (within ourselves) during the past decade. (Like all conflicts, I presume, each of us has to solve it as it relates to the inner rewards that accrue in meeting his or her own personality needs! To do otherwise would be a disservice both to ourselves and to the troubled children we hope to serve.)

But are the basic tenets, methods, and approaches of the modern community mental health center completely new and foreign to the child psychiatrist? I submit that they are not and therefore should not create disabling conflicts within him. The fact is that if the community mental health center had *any* traditional home, it was the traditional American child guidance center.

Hence, again, in the interests of the alleviation of anxiety in regard to clinical dedication, let me cite another interesting cycle. This cycle is at work in respect to these demanded roles that child psychiatrists shall play as *consultants* to social agencies and as advisors to nonpsychiatric (or indeed nonsocial service) paramedical or dedicated indigenous workers in the broad field of child care—this is opposed to the traditional intensive and extended study and treatment of the behaviorally disabled child.

Let me again appeal to some interesting child psychiatry history. In the year 1939, when I went to the Judge Baker as a resident, one of the main thrusts (really *the* main thrust) of the work of the clinic was its widespread involvement of all of the social agencies in effecting the desired changes in the behaviors of the individual child and of the significant members of his family. In fact, it was the stated intention and promise of the active participation of the directors and staffs of Boston's social agencies that was the most compelling item that convinced Dr. Healy that he should move from Chicago to Boston. I should add that it was this newer emphasis on working through the personnel of all of the social agencies that differentiated the Judge Baker in its operations from Chicago's Institute of Juvenile Research, and it was this agency collaboration, together with a broadening of the base of accepting troubled children not only from courts but from the agencies and from the child's family itself, that established the general child guidance center as a contribution to our culture.

The actual inner workings and operations of this clinic were that the child patient was seen twice—once by the child psychiatrist who got the child's own story and once by the psychologist for testing. The patient's parents (usually only the mother) were seen once and a home visit was made. The case was then conferenced; a prescription, plan, and program were arrived at, and at least seven times out of ten, the staff representative from one of a host of cooperating social agencies was present and continued the work with the child and the family as suggested in this consultation method.

Only later came the initiation of programs of intensive individual psychotherapy, and these programs were initiated as a result of the introduction of

modified psychoanalytic concepts, insights, and methods relating to mental health care. The periods of intensive individual treatment were lengthened from weeks to months—then to a year or years.

We have come full circle; and that we have done so may arouse in us a feeling of *déjà vu*, which certainly should not seem strange to us; its familiarity should modify our anxieties.

Having attempted to explore the feelings and the thinking of the child psychiatrist of the present moment with a view always to the alleviation of any prevalent anxieties, I think it is incumbent upon me as a veteran participant in all these clashes to comment upon what *I* think are stands, general and specific, that I would take in respect to these inordinate but just demands for adequate mental health services for children and for the expected diversities in the child psychiatrist's contribution.

1. In a most general way, I suppose that I would plead for a judicious balance in the application of our limited child mental health care expertise in patient care. Those who feel dedicated to the care of the individual child will be balanced, I hope, by those who wish to take active part (applying psychiatric principles to the social scientists' efforts) in the "revolution." The individual mental health worker's colleagues should not be prejudiced against him, regardless of which path he chooses to follow.

2. As to the public's rightful demands for multivaried expertise on the part of the child psychiatrist and the clinical child psychologist, I see no way out but through the development of highly specialized training programs for highly specialized areas of function. The day of the generalist in child psychiatry and the generalist in child clinical psychology, social work, or education is dead as far as caring for the health needs of maladjusted children (emotionally *or* educationally) is concerned. Training programs and clinical experience as they relate to all these disciplines (child psychiatry, child clinical psychology, and teacher education) will have to be modified to effect this needed specialization.

3. In respect to the possible existing conflict between the traditional medical model of individualized treatment and the epidemiological approach embraced by the community mental health center model, I would emphasize the following:

a. The community mental health center with its emphasis on early detection and intervention—with the utilization of consultation to educable and indigenous citizenry—should be encouraged by our professional participation. Encouragement by all (as citizens) should be afforded those who are trying desperately to modify negative mental health aspects in our communities.

b. As a backup to every community mental health center that deals with children, there should be a well-organized and well-staffed child psychiatric clinic whose function it will be to offer intense psychotherapeutic (and pediatric) diagnostic and treatment services to afflicted individual children whose problems are so internalized that no modification or alteration of their environments can be expected to be efficacious. Always and forever I see the need to supplement the "advocacy" and "detection-intervention" roles of the community mental health center with a center or clinic dedicated to and expert in individual treatment. May I remind you that in the establishment of community mental health centers it has been very easy to forget the establishment of a specific section or division that is to deal solely with the mental health problems of *children* and their parents.

In the presence of these unmet needs and our conflicts relating to our own identities and dedications we are inclined to look upon our historical present moment as comparable to Charles Dickens' "worst of times." Let me very briefly outline for you why I, as a professional, feel that we are heading (in the child mental health field) toward what I think are to be "the best of times."

1. The first and most important item is that with the report and recommendations of the National Commission on the Mental Health of Children we have for the first time placed on public record the case for children in respect to their mental health. Though one may quarrel with some of the emphases—or with some of the *lacks* in emphases in that document—in the overall it does tell the public and the members of our governmental structures where we wish to go in the future.

2. A second item of importance is the establishment of many and different citizens and lay groups who are interested in furthering the mental health care of children in selected disease categories.

3. A third item of importance (growing out of the National Commission's report) is the possible establishment of a child health advocacy system, culminating at the top with a President's Advisory Council on Children.

4. The newer emphases upon early detection, intervention, and prevention of childhood disabilities are to be welcomed and forwarded.

5. The newer emphases and new methods for parent education (particularly for mothers) through models such as Headstart and parent-child centers.

6. Of great importance I feel is the public's (and the mental health workers') present-day newer interest in and concern for children with intellectual deficiencies and learning problems. Too long were these disabilities considered as peripheral to our main professional concerns.

7. Finally, as an item for optimism on my part, is the avowed idealism of our youth—an idealism embracing their determination to devote a major portion of their lives to *service* for their fellowmen. We in the universities, the medical schools, and the clinics are already cognizant of this serious service dedication of our youth—and, indeed, they are already joining our ranks. Such idealism will result in both increasing our greatly inadequate child mental health manpower and will place in society newer citizens who will strive with us for more and better health services.

I must conclude with a quotation from Ralph Waldo Emerson that I feel is apt. In his essay on circles (that I might term "cycles"), Emerson states:

> There is not a *piece* of science but its flank may be turned tomorrow; there is not any literary or scientific reputation—even the eternal names of fame—that may not be reviled and condemned. The very hopes of man, the thoughts of his heart, the religions of nations, the manner and morals of mankind—are all at the mercy of a new *generalization*! And a new generalization is always a new influx of the divinity into the mind of man.

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